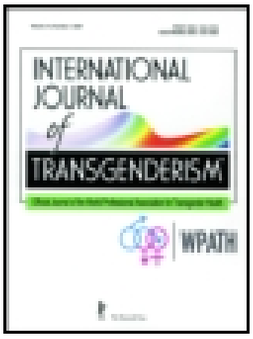

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Influences of health care access on resilience building among transgender and gender non-binary individuals

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ABSTRACT

Background: Health care disparities between transgender/gender non-binary individuals and the general population are well-documented and related to both interpersonal and institutional discrimination. Resilience has been found to buffer the negative health effects of discrimination among gender diverse individuals as well as other stigmatized populations.

Aims: The purpose of this study was to identify and understand resilience related to health and health care among a community sample of transgender and gender non-binary individuals in the southern United States.

Methods: We conducted 35 longitudinal photo elicitation interviews with 21 participants among a community sample of transgender and gender non-binary individuals in the Southern US. Interview transcripts were coded using thematic analysis and themes were organized according to the Resilience Activation Framework.

Results: Overall, individual and community-level resources within the domains of social and human capital were frequently activated to navigate challenges related to seeking and receiving health care. Lack of access to resources in economic and political capital domains constrained resilience.

Discussion: This work demonstrates how stakeholders can identify target areas for interventions and policy change aimed at improving resilience in transgender and gender non-binary communities by utilizing the Resilience Activation Framework. In our sample, we found that resources should be directed toward building economic and political capital at the community level so participants have the ability and opportunity to marshal such resources.

KEYWORDS
Health care; LGBT; resilience; transgender; non-binary

Introduction

Transgender and gender non-binary individuals[1] (TG/GNB) are among the most stigmatized members of our society (Gordon & Meyer, 2007; Miller & Grollman, 2015; Norton & Herek, 2013). We see evidence of this stigmatization in inequity within employment, housing, arrests and imprisonment, and health, among others (James et al., 2016). For example, compared with the general population, transgender individuals experience significant physical and mental health disparities including higher rates of HIV/STI infection, drug and alcohol use, self-harm, and suicide attempts (Grant et al., 2011).

While some TG/GNB fully express their gender without medical intervention, others rely on interventions such as hormone replacement therapy and gender affirming surgeries to express their gender. Unfortunately, health care is often an instance where TG/GNB are subjected to discrimination (Bradford, Reisner, Honnold, & Xavier, 2013; Grant et al., 2011; Poteat, German, & Kerrigan, 2013). A growing body of literature demonstrates that this discrimination is both interpersonal and institutional, coming from staff and providers who lack experience, education, and empathy around gender diversity, as well as both cisnormative and heteronormative[2] processes and policies (Bauer et al., 2009; Chisolm-Straker et al., 2017; Jaffee, Shires, & Stroumsa, 2016; Nadal, Skolnik, & Wong, 2012; Redfern & Sinclair, 2014).

With some important exceptions (Baldwin et al., 2018; Benbow & Kingston, 2018; Pearce,

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2018; Ross & Castle Bell, 2017), much of the existing research on the health of TG/GNB utilizes a deficits- or risk-based approach. However, recent research demonstrates the necessity and utility of strength-based approaches to studying gender diverse communities (Colpitts & Gahagan, 2016). Strengths-based approaches allow researchers to focus on how individuals and communities meet the challenges posed by stigma and discrimination, rather than the deficits stigma and discrimination create (Colpitts & Gahagan, 2016; Smith & Gray, 2009). Understanding resilience is one such approach. Resilience is generally conceptualized as a process of positive adaptation to adversity that minimizes the potential negative effects of stigmatization on health (Follins, Walker, & Lewis, 2014; Meyer, 2015; Singh, Hays, & Watson, 2011). Though most is specific to transgender-identified individuals, previous research on resilience in TG/GNB demonstrates strategies such as cultivating self-esteem, self-acceptance, and pride in identity in building resilience (Grossman, D'Augelli, & Frank, 2011; Singh et al., 2011; Singh & McKleroy, 2011). In this population, resilience is associated with lower levels of psychological distress (Breslow et al., 2015).

The Resilience Activation Framework (RAF) (Abramson et al., 2015) is a translational and multi-disciplinary framework useful for both qualitative and quantitative exploration. Originally designed for research on community disaster response, it has also informed research on trauma and health emergencies (Lichtveld et al., 2016). To our knowledge, this is the first study to apply the framework to understand resilience in response to chronic social stress within a functional and structural community. Abramson and colleagues conceptualize resilience as a process that occurs when individuals and communities are able to conserve or marshal resources, termed "resilience attributes," in response to adversity. In their framework, resilience attributes are organized around four "resource areas," or "domains" of capital: social, human, economic, and political. According to the RAF, individual and community level resource attributes interact with each other, both within and across domains, such that access to community level resources can facilitate the activation of individual level resilience attributes, and resilience in one resource area can foster resilience in another (Abramson et al., 2015). This framework is particularly useful for our purposes because, as the authors suggest, it "provides a roadmap for action that could potentially impact behavioral health intervention practice, policy and research" by identifying existing areas of resilience as well as areas where resources are limited and, thus, where resilience can be built (Abramson et al., 2015, p. 11). Table 1 presents the original RAF expanded to include a definition of each type of capital and the associated individual and community level resilience attributes we identified in the present study.

Study purpose

The purpose of this study was to identify and understand resilience related to health and health care among a community sample of TG/GNB in the southern United States. Through understanding where resilience is strong, and where it is lacking, we can better target health promotion strategies aimed at improving individual and community resilience.

Methods

This study is part of a larger, community-based research project (Israel, Schulz, Parker, & Becker, 1998) that utilized a mixed-methods approach to explore resilience among TG/GNB. All study protocols and procedures were approved by the first author's institutional review board. We conducted photo-elicitation interviews, in which interview questions are prompted by participants' photographs (Hensel, Newcamp, Miles, & Fortenberry, 2011; Padgett, Smith, Derejko, Henwood, & Tiderington, 2013), with 21 individuals. Photo-elicitation interviewing assists participants in discussing abstract concepts through verbal as well as visual description empowering the participants to direct the interview content (Bowling et al., 2017; Hensel et al., 2011), and has previously been used to guide projects meant to address health and social disparities across diverse populations (Hensel et al., 2011;

Table 1. Resilience attributes at community and individual levels related to transgender and gender non-binary healthcare.

	Social Capital	Human Capital	Economic Capital	Political Capital
Community Level Resilience Attributes	*Social networks, social status, social cohesion*	*Access to medical care, education, training, expert knowledge*	*Median household income, tax revenues, employment, occupational diversity*	*Capable governance, fair distribution of resources*
Interactions between Levels of Resource Attributes	+ Social networks for health information sharing + LGBTQ advocacy organizations provide support	+ Trans Healthcare Group providing care + Access to expert knowledge, LGBTQ competent providers	-Employment discrimination led to economic instability and lack of insurance	- Policy changes and funding issues left people uncertain about their access to care
	Interactions between Domains of Capital			
	Family, friends, coworkers, perceived social support	*Temperament, optimism, self-efficacy, coping, psychobiological, parenting*	*Household income, savings, access to credit/loans*	*Ability to vote, access to people in leadership or those distributing resources*
	+Allies within healthcare +Chosen family - Partners opinions and concerns about medical transition	+Persistence in advocating for care +Pride in self-managing care +Coping with limited access to care + Flexible mindset in reframing health challenges	-Lack of economical capital was a barrier to receiving transition related care	+ Building relationships with politicians + Policy literacy
Individual Level Resilience Attributes				

Constructs in italics from Abramson et al. (2015)

Kantrowitz-Gordon & Vandermause, 2015; Padgett et al., 2013). Responding to a call for longitudinal explorations of resilience (Ungar, 2011), we conducted follow-up interviews six months after the first.

This study is based in a partnership with an organization serving TG/GNB in the community and incorporates several tenets of community-based research, including viewing the community as a unit of identity, incorporating community feedback, and using dissemination for the benefit of all partners (Israel et al., 1998). We developed the first interview guide in consultation with our lesbian, gay, bisexual transgender and queer (LGBTQ) community partners. We recruited purposively through our partner organization as well as other community LGBTQ- and gender diverse-focused organizations (including local support groups and health care organizations). To reach individuals who may have been less connected to these organizations, we created a study page on Facebook and posted advertisements to individuals in Charlotte, NC interested in gender and sexuality topics.

To be eligible to participate, individuals needed to identify as gender diverse (i.e. trans, gender non-binary, gender queer, gender non-conforming), be at least 18 years of age, and live in the Charlotte, NC area. After affirming their eligibility and consenting to participate, all participants completed a brief survey that included demographic (age, gender identity, race/ethnicity, sexual identity, and contact information) and contact information. Participants selected their own pseudonyms, provided their gender identity labels, and stipulated their pronouns, all of which we use throughout this article.

Before the first interview, participants were asked to take 5 digital photos in response to the question "How are you strong?". They were instructed that photos could be literal or metaphorical and may represent their strength or when they felt less strong. We provided the following guidelines: photos must be participant's original work, and include no identifiable information (faces, ID cards, etc.). Each participant's photos were displayed on a screen during their first in-depth interview, which typically lasted between 60 and 90 min. All interviewers, including one faculty and two student researchers, were white, cisgender women. The first interview focused on the content of the participants' photos, health (as defined by the participants), and local resources' influence on health. Questions

began with "Can you tell me a little about what's happening in this photo?" and follow-up questions asked about the content of the photo (i.e. significance of depicted object, importance to other areas of their life) and photo composition (i.e. angle, lighting, framing).

All interviews were audio recorded and transcribed by a third-party transcription company. We inductively coded the interview transcripts using a thematic coding approach in which interview data points were summarized into common themes (Thomas, 2006). Analysis was conducted with Dedoose online qualitative software (Dedoose, 2018). A preliminary coding framework was established inductively based on the interview guides, and developed iteratively through coding initial interviews. Each interview was coded independently by two of four coders (including two of the interviewers and two additional graduate students—one who identifies as a black, cisgender woman and another who identifies as a white, cisgender man). Coders "memo"ed (attaching notes to specific excerpts of the data in Dedoose) throughout the coding process to identify potential bias introduced by our different social locations, confusion, and thought processes (Richards, 2014); these were then used for group discussion and code refinement. Reliability amongst coders was confirmed using Dedoose's test function. Where Kappa was less than 0.80, we discussed and/or edited until consensus was reached amongst the coding team. We then deductively organized these themes according to the resilience attributes as outlined by Abramson et al. (2015).

After the first interviews were analyzed, we held a community meeting to discuss preliminary findings and receive input on topics to include in the second interview protocol. Community members agreed that social support, faith, and changes since the first interview should all be included in the second interview. Fourteen of our initial 21 participants sat for a follow-up interview approximately six months after the first. In the second interview, interviewers summarized previous findings to identify changes over time and conducted a brief member check on the overarching themes their first interview touched on (e.g. political involvement as a resilience strategy).

Table 2. Photo-elicitation interview participant self-identified descriptions ($N = 21$).

Pseudonym	Age[a]	Race/ethnicity	Gender identity
Lara[b]	32	Latinx	Trans woman
Aurora[b]	27	White	Trans woman
Dawn	20	Latina	Trans woman
Espn[b]	32	White	Trans woman
Lynette[b]	28	White	Trans woman
Amy	25	White	Trans woman
Flynn[b]	68	White	Trans woman/strongly female
Natasha	43	White	Male to female trans
Siobhan[b]	62	White	Female with an extra part
Samara	19	White	Trans femme
Elijah	30	White	Trans man
Lake[b]	26	White	Trans masculine
Toby[b]	19	White	Male that happens to be trans
Hava[b]	34	Mixed	Gender queer
BioDoc[b]	42	White	Gender queer
T	18	White	Gender non-binary
Nicole	20	African American	Gender non-binary
AshWilliams[b]	24	African American	Gender non-binary
Ciara[b]	24	African American	Gender non-binary
Joy[b]	41	White	Gender non-binary
E[b]	29	White	Everything

[a]Age during first interview.
[b]Participants completed two interviews.

Findings

Participant demographics are described in Table 2. Nearly half of participants were trans women or femme[3] (48%, $n = 10$), while 38% of participants identified as genderqueer/non-binary ($n = 8$), and 14% as trans men or masculine individuals ($n = 3$). Ages ranged from 18 to 68 years, with an average of 31.6 years. The majority of the sample was white (71%, $n = 15$). During their interviews, most participants (81%, $n = 17$) reported current or past psychological distress. Seventy-five percent of participants had ever accessed mental health care ($n = 16$). Less than half described their overall health as good or stable (43%, $n = 9$), and of these participants 75% accessed local mental health care either in the past or currently ($n = 6$).

Our findings are discussed below ordered according to the Resilience Action Framework (Abramson et al., 2015): organized around the four domains of capital and their associated community and individual level resilience attributes (see Table 1). During their interviews, participants discussed or demonstrated resilience around two domains in particular: social capital and human capital. Economic and political capital were domains where resilience attributes were limited, which challenged participants' ability to build resilience. Representative quotes from participants' interviews are introduced to

demonstrate the findings. Figure 1 includes relevant participants photos.

Social capital

Attributes of social capital at the community level include social networks, social support, and social cohesion. Accordingly, our participants discussed how their social networks served as resources for information-sharing and help navigating health care. For example, participants reported getting information about health care protocols (e.g. hormone replacement therapy dosages) and gender diverse-friendly providers from internet forums and groups organized around gender-diverse identities. These social networks grew out of a challenge some in the community faced accessing gender affirming care. That our participants struggled to identify competent and willing providers, or get themselves into health care, was evidence of limited *human* capital at the community level. In the face of this challenge, support systems became vital. Additionally, participants described finding individual 'allies' within health care systems who would help them navigate the systems and policies. Siobhan (62 years, female with an extra part) provided an example of this by describing her pharmacist as one such resource, saying she "*goes out of her way*" to find cheaper estrogen [for me] that requires fewer painful injections.

At the individual level, attributes of social capital include interpersonal relationships with peers and family members and perceived social support. Our participants described how relationships with their family and friends contributed to their resilience. Samara (19 years, trans femme) for example, described how her sister always makes sure there are "safe foods" for Samara's autism at the house: "*It's the youngest of my three sisters that really has always been there for me like a mom.*" Another example of how our participants utilized social capital to build resilience can be drawn from AshWilliams (24 years, gender non-binary), who discussed wanting to see a therapist in their first interview, but the effort it took to find a mental health care provider and getting to therapy were barriers. AshWilliams thus relied on their "chosen family"—a social capital resource—to process their experiences. By the second interview, they had started therapy but still relied on chosen family to fill in gaps in their care, and even provided mental health support for others. AshWilliams' story also demonstrates another feature of the RAF, interactions between multiple domains of capital; they overcame barriers to health care (limited human capital resources) through relying on interpersonal relationships (a resource of social capital) and ultimately became a resource for others. As described below, interactions occurred around other domains of capital as well.

One challenge to resilience within the social capital domain was partner concern about gender-affirming treatment (e.g. breast feminization, or orchiectomies, the surgical removal of the testes). Partners' opinions influenced participants' health care decision-making and resulted in delaying desired care. One participant described choosing vaginoplasty rather than an orchiectomy, despite the higher cost and long waitlist for the procedure, because her partner did not like the way surgical removal of the testicles would change her body. Similarly, Lara (32 years, trans woman), was debating options in transitioning because of her partner's family planning goals, saying "[partner name]'s hinting that she wants a baby, so there's a small chance that I can make that happen with my anatomy. But I'd have to be off of hormones for six months, which is kind of devastating." Another participant, Siobhan, found that breast feminization wasn't covered through insurance because she didn't want to have bottom surgery as well. Her wife also didn't support the expense of the augmentation, saying "Here we go through the retirement money again, I had to spend ten grand on a pair of boobs that my wife didn't think I needed" (Siobhan, 62 years, female with an extra part, see Figure 1a for a portrait). Siobhan's example also demonstrates interactions between domains of capital, in this case limited economic capital interacting with social capital (partner support). It wasn't simply the significant changes to participants' bodies that concerned their partners, but the significant financial burden of those changes.

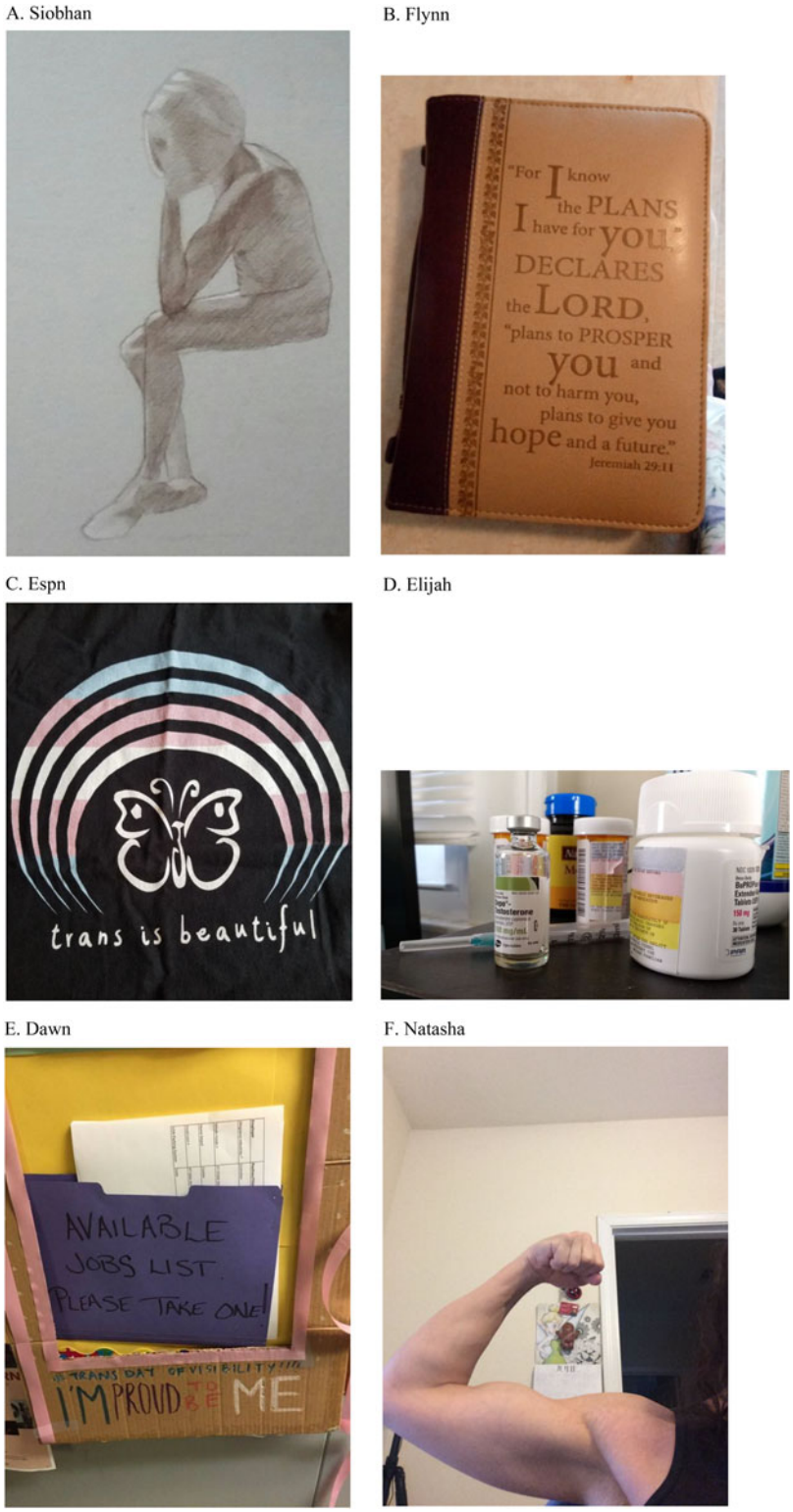

Figure 1. Selected participant photographs related to healthcare and resilience.

Human capital

At the community level, attributes of human capital include access to medical care and expert knowledge. In our study, the availability of trained medical providers and a local trans health care organization contributed to resilience. Lynette (28 years, trans woman), described the local trans health care organization saying, "I did a lot of research first, but I found [local health care system] is a great system, especially

[because] they have experience and knowledge about the LGBT world. They just know what they're doing." When providers had gender-affirming care credentials or training completions, participants felt they were better able to trust them. For example, Elijah (30 years, trans man), was concerned about HRT, but reassured himself by focusing on his medical provider's experience with transition-related care, "because I don't have all the results that I want, I worry that my T-levels aren't high enough, and to not give myself extra shots or put extra T in there, 'cause I'm like, 'The doctor knows what he's doing, so I'm just gonna keep going with this [testosterone regimen]'."

Attributes of human capital at the individual level include intrapersonal characteristics such as temperament, perceived self-efficacy, and coping skills. Participants' responses to stigma exemplified how participants draw on resources of human-capital to build resilience. Lara (32 years of age, trans woman) demonstrated this as she navigated processes at the Veterans' Affairs (VA) hospitals to receive care: "if there's a thousand people at the VA, seven of them are cool with trans people." Interviewer: "How did you find those seven people?" Lara: "Being persistent."

An example of community level and individual level resources within the same domain interacting to foster resilience can be seen in Flynn's story. Flynn discussed how her mental health provider, who was trained in transgender issues, helped her reinterpret Biblical texts to assuage the deep stress she was carrying related to her gender identity. Flynn's mental health care provider—a resource in her community—helped Flynn to develop an individual resource to navigate stigma from within her religious community.

> I'd gone to seminary so I knew the scriptures, but she went down all the, we call the "clobber verses," which [are] the verses that the traditional church throws at you to condemn you. She went through every one of them in the Old Testament and said, "No. That's not what it says. This is what is says. This is what it meant. This is the context. They're taking it out of context." (Flynn, 68 years, trans woman; see Figure 1b for a depiction of Flynn's Bible cover).

Having a knowledgeable and culturally sensitive health workforce available in the community helped activate Flynn's individual-level coping skills.

Individual-level resilience attributes also strengthened and generated other attributes. Self-efficacy, for example, became a source of pride for Dawn (20 years, trans woman), who was proud of self-managing her hormones given the labor involved in her HRT: "I get [my hormones] through the gray market from a supplier in Singapore. I have to regulate everything myself, which is just pretty serious testimony toward all the extra labor that trans women have to do for everything." Not having access to HRT through traditional health care, on top of other challenges faced by trans women, characterizes the adversity that can build resilience when one can draw on individual attributes.

Participants also demonstrated a flexible mindset when faced with health-related challenges. For example, Espn (32 years, trans woman), reframed her long wait for gender-affirming surgery as an opportunity saying: "Dr. [name redacted] has a 3-year waiting list to get a bottom surgery done… But, it's three years that I can save up for it" (see figure 1c for a photo of Espn's t-shirt highlighting the pride in her journey). Elijah (30 years, trans man) also adopted a flexible mindset by reframing his reliance on mental health care saying, "It is a sign of maturity and self-confidence that I'm okay with needing them [medication] and okay with understanding that doesn't make me less" (see Figure 1d for a depiction of Elijah's medications).

Economic capital

At the community level, resources of economic capital include mean household income, tax revenue, and occupational diversity. At the individual level, resources of economic capital include income, savings, and access to credit or loans. At both levels, lack of economic capital challenged resilience. Specifically, employment discrimination because of transgender identity and subsequent job instability diminished access to health care through either employer-sponsored insurance or limited financial power. Dawn (20 years, trans woman) captured the incompatibility of

trans identity and having a "normal job" with job security and health insurance saying:

> Here you have Trans Day of Visibility, like a little frame that says, "I'm proud of me." But right in the middle of the frame, you can see a folder saying "Available jobs list, please take one." So, I thought that was a cool picture. [Laughs] "Cause you can't be proud of being trans and get like a normal job" (see Figure 1e for a depiction of a local LGBTQ organization's job board).

The challenges posed by limited economic resources meant some of our participants turned to alternative sources of care. Ciara, who was having trouble dealing with the financial burden of repeated medical tests, described this by saying, "I'll take a shot of apple cider and pray about it. Because that's cheap and actually doable" (Ciara, 24, gender non-binary). The relationship between health and economic instability was bidirectional, with poor health contributing to unemployment and unemployment exacerbating poor health.

While most of the participants contextualized their challenges related to health and health care through the stigma surrounding their gender, gender was not the only marginalized identity participants had to negotiate. For example, Nicole (20 years, gender non-binary), who identifies as black, also described how racism contributed economic barriers to health care:

> I was sick of paying $60 a month for an inhaler… Insur[ers] regularly [dis]qualify inhalers for insurance because they're debatable, and we all know why: because the black community [has] the highest rate of asthma… so one month my inhaler could be $300 and the next it's $60. And I was really sick of that. [chuckle] I've had it for the majority of my life, my childhood, regular hospitalizations for bad asthma attacks, that kind of stuff.

Like Nicole's, the narratives of participants who navigated multiple oppressions contained examples of how these multiple oppressions worked together to challenge resilience.

Political capital

Attributes of political capital at the community level include capable governance and fair distribution of resources, and the ability to vote and access to leadership at the individual level. As we found with economic capital, political capital resources were not easily marshaled. At the community level, the fair distribution of resources, specifically health insurance coverage, was a concern for participants. Participants described how uncertainty about insurance and identity documentation policies challenged health care access and use. Lynette (28 years, trans woman), for example, discussed the uncertainty of whether voice coaching would be covered through insurance.

> I'm still able to make it work and everything, but there's things that aren't covered that aren't really viewed as necessary to the insurance companies… Personally at this point in doing things, I found the voice stuff is very difficult. They don't cover vocal lessons or surgeries or anything like that.

In addition to navigating insurance policies, many participants discussed difficulty discerning which surgeries would be required for a legal transition.

Latent economic and political capital resources also interacted to create health care barriers for participants. Nicole (20 years, gender non-binary), who relies on Planned Parenthood for primary care, worried about the future of her care given the current conservative political climate saying, "how far ahead do I need to plan? Is this climate that we're in right now… how at risk am I and what can I do within the next six months before it's completely shut down? What can I do to keep myself alive?" Nevertheless, participants engaged in advocacy and activism, demonstrating resilience in the face of limited political capital, while attempting to build more. For example, Natasha (43 years, male to female trans) discussed building relationships with politicians in order to change their minds about trans individuals. She described working on her physical strength as well as emotional strength to continue this work (depicted in Figure 1g working out), "I've had to be physically and emotionally strong for not only myself, my family, but those who can't speak for themselves or are too afraid to. Somebody's got to do it" (Natasha). Here, marshaling resources to build individual resilience allowed her to engage in political activity that could contribute

to the political capital resources of the entire community.

Participants also demonstrated resilience through policy literacy, an individual-level resilience attribute within the political capital domain. Many participants described efforts to gain awareness of different policies that would impact their health (e.g. learning to navigate each branch of the Veteran's Affairs healthcare's interpretation of federal policies). In general, participants acknowledged policy as an often unknowable and powerful force in their lives; policy literacy allowed them to assert some control over their circumstances and health. For example, Espn used her policy literacy in negotiations with her new employers for gender-affirming care:

> I called the company I was with. "Do you guys do any gender-conforming surgeries?" "No, we won't put it on our insurance neither." I called the company I'm with now. "Do you guys do any gender-conforming surgeries, because you guys have Blue Cross Blue Shield, and I know that's one that offers." "We don't, but if you come on board and that's something that you want and need, we'll present it to the Board and try to get it on." (Espn, 32 years, trans woman).

In Espn's story, we find an example of how individual's resilience attributes, in this case policy literacy and comfort discussing gender-affirming care, can ultimately contribute resources at the community level. If the board of her new employer approves insurance coverage for those treatments, all employees who need them would potentially have access.

Discussion

Historically, resilience studies have focused on predominately white, heterosexual, cis-gender populations thus creating a gap in our understanding of resilience development and activation in gender minorities (Colpitts & Gahagan, 2016). This study helps fill this gap by introducing findings from an underrepresented group, transgender and gender non-binary individuals, into the larger body of resilience research. Further, this study adds to a growing body of research taking strength-based approaches to transgender health (Baldwin et al., 2018; Ross & Castle Bell, 2017; Singh et al., 2011). Our findings are useful to the larger community-based assessment project of which they are a part, but also to the larger project of addressing health disparities through program and policy development. While our specific findings cannot necessarily be assumed of other communities, our study demonstrates how the RAF (Abramson et al., 2015) can be used to assess resources and needs in functional and structural communities.

In our study, the domains of human and social capital provided more resources for participants to marshal, thus providing greater ability to develop resilience in those areas. Our findings are in line with existing research that highlights individual agency in understanding, building, and utilizing resilience strategies for TG/GNB (Singh et al., 2011) and the importance of social capital, collective affiliation, and community to transgender individuals' resilience (Lev, 2007; Sánchez & Vilain, 2009). In much the same way that racial and sexual minorities draw on community-level resources, and access these resources through community specific spaces (e.g. churches, gay bars), (Kubicek, McNeely, Holloway, Weiss, & Kipke, 2013; Walker & Longmire-Avital, 2013), our participants leveraged a community of genderdiverse members for health information when access to care was limited, and relied on advocacy organizations built by and for the local LGBTQ community to get health care and other social support (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Glick, Andrinopoulos, Theall, & Kendall, 2018; Pflum, Testa, Balsam, Goldblum, & Bongar, 2015; Singh et al., 2011). Further, the community from which our sample was drawn had a trans-specific health care group and a range of available providers who were competent in LGBTQ care if they needed to leave a discriminatory, hostile, or ignorant provider. Previous studies have demonstrated these issues in particular are common for trans people and contribute to delaying or forgoing care (Glick et al., 2018; Jaffee, Shires & Stroumsa, 2016; Kosenko, Rintamaki, Raney, & Maness, 2013), including trans individuals in a geographically similar area (Stepleman et al., 2018).

By using the Resilience Activation Framework (Abramson et al., 2015) to map out the resilience attributes of TG/GNB within a specific community, we also determined where health programs and services can be targeted to build resilience. Meyer (2015) points out that for LGBTQ individuals, resilience is related to social identity and community affiliation. We found evidence of this in our study; social capital was strengthened through awareness of a gender diverse identity and finding community around that identity. As with previous studies (Bauer et al., 2009; David, 2017; Davy, 2016), lack of economic and political capital challenged resilience building among our participants. This is, in part, related to the overall context of gender diverse stigma in the U.S. because individual resilience is limited by community resilience attributes (Meyer, 2015). Just as the local community can hinder individual resilience, one may imagine that local community resilience may be hindered by larger social contexts. Given that TG/GNB in the U.S. face economic and political marginalization (National Center for Transgender Equality, 2016), limitations at the local community level in these domains are not surprising. And given that stigma and discrimination at social and structural levels has negative influences on health, public health efforts to address disparities between gender diverse and cisgender individuals must contend with these upstream determinants, even those that seem less directly associated with health (e.g. political capital).

Clearly, in our community, resources should be directed toward building economic and political capital so participants have the opportunity to marshal such resources. In the face of community adversity in these areas, developing policy literacy and relationships with policymakers may be ways for individuals to become more resilient and build a more resilient community. As part of a community-based research project, our findings laid the groundwork for a follow-up study aimed at resilience building around general health and health care at the community level. Our findings also provided targets for future community work to address upstream determinants our participants described, including insurance information-sharing discussions, opportunities for advocacy with local political leaders (e.g. inviting leaders to events such as Trans Day of Remembrance), and improving access to education and employment for TG/GNB in the local community. We further identified a need to enhance the empathy and understanding not simply of the whole community, but also those intimately connected to our participants: relationship partners.

The Resilience Action Framework proved useful for studying marginalized groups because of its dual focus on individual and community-level resources and the interactions between attributes at these levels and across different domains of capital. In doing so, it provides a way of examining the relationship between structural barriers and individual agency in activating resilience. Additional research on resilience that incorporates the reciprocal relationships between levels and of domains of capital is needed.

Limitations

There is ongoing debate about how best to conceptualize and measures resilience in LGBTQ individuals and communities, especially regarding the necessity of LGBTQ-specific models (Colpitts & Gahagan, 2016; Dickinson & Adams, 2014). Our use of the RAF, which was not developed to understand resilience in marginalized communities, may have influenced what was interpreted as resilience (Patel et al., 2017; Singh & McKleroy, 2011). If we had utilized a different analytic framework, we may have had different findings. And, while our sample included both trans and gender non-binary individuals, it was limited in the inclusion of trans masculine individuals. Further, recent work on gender non-binary individuals' experiences in health care (Lykens, LeBlanc, & Bockting, 2018; Paine, 2018), provides evidence for differentiating between trans and gender non-binary individuals' strategies of resilience in the health care setting. Our sample and methodological approach did not allow us to do so.

Finally, while a few participants discussed multiple marginalization related to race and ethnicity, our sample was not inclusive enough of racial and ethnic minority individuals to explore this in-depth. The homogeneity of the researchers (cisgender and white) demanded that we utilize community-engaged and reflexive practices to

mitigate any biases. The community-based foundation of the research project, coupled with member checking and discussing potential biases throughout data analysis and interpretation, assisted in mitigating the effects of biases.

Conclusions/implications for future work

Our understanding of resilience among marginalized populations continues to grow, especially as we explore the ways in which resilience is a feature of individuals, their communities, and interactions between the two. This study adds evidence to the need for strengthening economic resources and stability, as well as tailored healthcare interventions for these limited economic resources, among TG/GNB. The continued lack of political capital for this population likely contributes to discrimination and stigma, though we describe some of the strategies TG/GNB use to build individual political capital. There remains a need to identify theoretical frameworks of resilience that can be applied to gender diverse groups as research indicates this group represents some of the most marginalized in our society. The Resilience Activation Framework (Abramson et al., 2015) allows us to understand what resilience looks like in a community of trans and gender diverse people and can directly inform programing intended to address health disparities between them and the general population. By using a similar approach, stakeholders (including policymakers, health care providers, public health practitioners, and gender diverse advocates) in other communities can identify areas where resilience can be strengthened and thus lead to more efficient use of what are often limited resources for improving the health of TG/GNB.

Conflict of interest

The authors declare that they have no conflict of interest.

Ethics statement

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent was obtained from all individual participants included in the study. Participants consented to have their photographs included in publications of this research.

Notes

1. Gender non-binary refers to those whose gender does not correspond to "man" or "woman," including gender queer, gender fluid, agender, among others.
2. Cisnormative refers to assumptions that a person's gender corresponds to the sex they were assigned at birth and heteronormative refers to assumptions that an individual is heterosexual in their identity and/or behaviors.
3. Femme here is used to describe gender queer individuals who present and/or act in feminine way.

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